

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 19 January 2007**

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**In the Matter of:**

**E.B., widow of  
O.B., deceased,**  
Claimant,

v.

**Case No. 2005-BLA-05307**

**INDIAN MOUNTAIN COAL CO./  
OLD REPUBLIC INSURANCE CO.,**  
Employer/Carrier, and

**DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS,**  
Party-in-Interest

.....  
**Appearances:**

Andrew Delph, Esquire, Wolfe, Williams, & Rutherford, Norton, Virginia  
For the Claimant

Joseph W. Bowman, Esquire, The Street Law Firm, Grundy, Virginia  
For the Employer/Carrier

Before: PAMELA LAKES WOOD  
Administrative Law Judge

**DECISION AND ORDER GRANTING BENEFITS**

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter “the Act”) filed by E.B. (“Claimant”) on October 14, 2003, based upon the death of her husband, deceased miner O.B. (“Miner”). The putative responsible operator is Indian Mountain Coal Co. (“Employer”) which is insured through Old Republic Insurance Co. (“Carrier”). Benefits are being paid by the Black Lung Disability Trust Fund.<sup>1</sup>

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<sup>1</sup> The term “Employer” will encompass both the Insurance Carrier and the Employer.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001.<sup>2</sup> 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.<sup>3</sup> The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

### STATEMENT OF THE CASE

Claimant filed this claim for survivor's benefits on October 13, 2003, following Miner's death on May 31, 2003. (DX 2). On April 19, 2004, the Director issued a Schedule for the Submission of Additional Evidence. (DX 18). The Director determined that Claimant would be eligible for benefits and Employer would be responsible for paying them. *Id.* Employer contested this designation by way of letter dated May 6, 2004. (DX 20). Director then issued a Proposed Decision and Order on August 4, 2004, awarding Claimant benefits and finding Employer liable. (DX 21). Employer also contested these findings and requested a hearing before this office by way of letter dated September 2, 2004. (DX 23). The Black Lung Disability Trust Fund initiated payment of benefits because Employer chose not to pay benefits. (DX 26).

A hearing was held before the undersigned in Abingdon, Virginia on September 30, 2005. Claimant's Exhibits 1 through 3 ("CX 1" through "CX 3") were admitted into evidence. (Tr. 20, 22). I informed the parties that Claimant's Exhibit 3, the report of Dr. Perper, would be admitted with the understanding that inadmissible evidence discussed in the report would not be considered. (Tr. 22). I also admitted Employer's Exhibits 1 through 15 ("EX 1" through "EX 15"). (Tr. 44). Claimant was the only witness to testify at the hearing. The parties did not give closing statements, but agreed to submit closing briefs. (Tr. 46). At the end of the hearing, I informed the parties that I would allow the record to remain open for sixty days so Employer could respond to Claimant's Exhibits 1 and 2, which were x-ray readings, because Employer had not received them and therefore did not have a proper chance to respond. (Tr. 47). By way of cover letter dated November 29, 2005, I received Employer's x-ray rebuttal to Claimant's Exhibit 1, which has been marked as Employer's Exhibit 16 (EX 16). I received Employer's response to Claimant's Exhibit 2 by way of cover letter dated January 17, 2006, which has been marked as Employer's Exhibit 17 (EX 17). Having received these exhibits, EX 16 and 17 are hereby admitted into evidence and the record is now closed. **SO ORDERED.**

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<sup>2</sup> Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

<sup>3</sup> Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

Claimant submitted a closing brief on the merits on January 30, 2006. Employer did not submit a closing brief, nor has it indicated that it intends to do so.

### **Issues/Stipulations**

The contested issues before me are Miner's length of employment, whether Miner had pneumoconiosis, whether pneumoconiosis arose from coal mine employment, whether Miner's death was due to pneumoconiosis, and whether Employer is the proper Responsible Operator. (DX 28; Tr. 12-14).

At the hearing, counsel for Employer agreed that whether Miner was disabled or not was not an issue in the instant claim, and had been incorrectly listed. (Tr. at 12). None of the other issues were withdrawn by Employer. (Tr. at 13-14).

### **Employment History/Background**

At the hearing, Employer continued to contest its designation as Responsible Operator. (Tr. 13). However, through counsel, Employer admitted that it had no evidence to submit on the issue. *Id.* Under 20 C.F.R. §725.495(c), a designated responsible operator bears the burden of proving either it does not have the funds to pay benefits or it is not the most recent responsible operator to employ the miner. Since Employer has presented no evidence showing that it would fall in either of these categories, I find that the Director's decision to name it Responsible Operator for purposes of adjudicating this claim is appropriate. Employer did illicit testimony from widow that Miner was a 1/3 owner of Employer, but offered no further evidence or arguments.<sup>4</sup> (Tr. at 33-34).

Claimant testified at the hearing that she had been married to Miner for 47 years at the time of his death. (Tr. at 28). She testified that Miner had worked for 22 years in coal mines, with short periods of layoffs, until 1978. (Tr. at 29). According to what Miner told her, Miner's jobs included operating a bulldozer, drilling, and doing some lumber work. (Tr. at 33). Claimant was unaware of whether or not Miner wore a respirator when he worked. *Id.* She also testified that Miner was often covered in dust upon returning home from work. (Tr. at 30). Claimant also testified that Miner had extensive breathing problems. (Tr. 30). Miner was on six liters of oxygen 24 hours a day at the time of his death. *Id.* Claimant never smoked, and as far as she was aware, Miner never smoked either. (Tr. at 31).

### **Medical Evidence**

The newly submitted medical evidence in this case is listed below. Interpretations of chest x-rays taken August 24, 1998, September 28, 2000, and February 08, 2002, all of which utilize the ILO system and are in compliance with the regulatory standards, are summarized below:

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<sup>4</sup> Miner's ownership of Employer would not bar his entitlement to Black Lung benefits. *Cf. Lovilia Coal Co. v. Williams*, 143 F.3d 317 (7th Cir. 1998) (finding insurance company liable to pay benefits to partner/owner who worked as a coal miner during the policy period, for whom premiums were not paid.)

<b>Exhibit No.</b>	<b>Date of x-ray/ Reading</b>	<b>Physician/ Qualifications<sup>5</sup></b>	<b>Interpretations</b>
CX 1 Claimant's Initial	08/24/98 10/01/98	K. DePonte B-reader BCR	1/1; q/q; six zones; Parenchymal abnormalities consistent with pneumoconiosis; presence of Category A large opacities; Quality 2.
EX 16 Employer's Rebuttal	08/24/98 03/02/00	W. Scott B-reader BCR	1/1; t/q; four zones; Parenchymal abnormalities consistent with pneumoconiosis; minimal right hemidiaphragm; profusion more likely due to healed tuberculosis rather than coal workers' pneumoconiosis; Quality 1.
EX 4 Employer's Initial	09/28/00 12/14/00	J. Castle B-reader	1/1; t/t; five zones; Parenchymal abnormalities consistent with pneumoconiosis; evidence of elevated right hemidiaphragm; No presence of coal workers' pneumoconiosis, consistent with interstitial pneumonitis. Quality 1.
CX 2 Claimant's Initial	02/08/02 02/11/02	K. DePonte B-reader BCR	2/1; u/r; six zones; Parenchymal abnormalities consistent with pneumoconiosis; presence of Category A large opacities; Quality 1.
EX 17 Employer's Rebuttal	02/08/02 12/13/05	P. Wheeler B-reader BCR	No presence of coal workers' pneumoconiosis; Quality 1.

Two pulmonary function tests were submitted by Employer in support of its case. The first was conducted by Dr. Joseph Smiddy, M.D. on April 28, 1982. (EX 1).<sup>6</sup> Dr. Smiddy's test produced FEV1 values of 3.29, FVC values of 4.03, and a FEV1/FVC percentage of 82. *Id.* A bronchodilator was not administered. The second examination was conducted on January 24, 2000, by Dr. James Castle, M.D. (EX 4). Dr. Castle's pre-bronchodilator examination produced FEV1 values 1.51, FVC values of 1.94, FEV1/FVC percentage of 78, and MVV of 55. *Id.* After administering a bronchodilator, Dr. Castle received FEV1 values of 1.75, FVC values of 2.31, a FEV1/FVC percentage of 76. *Id.*

Under subparagraph (i) of section 718.204(b)(2), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ration of less than 55%. None of the above results were qualifying. Of course, since this is a survivor's claim, whether or not Miner was totally disabled under the regulatory criteria as a result of pneumoconiosis is ultimately irrelevant.

<sup>5</sup> BCR refers to a board certified radiologist. A B-reader is a physician certified by the National Institute for Occupational Safety and Health ("NIOSH") to read x-rays.

<sup>6</sup> Dr. Smiddy's credentials are not of record.

In support of its case-in-chief, Employer also submitted two arterial blood gas (“ABG”) examinations. Both were conducted by Drs. Smiddy and Castle on the same dates as the pulmonary function tests listed above. (EX 1; EX 4). Dr. Smiddy’s ABG test produced resting PCO2 values of 31.7 and PO2 values of 81.6. (EX 1). No exercise values were obtained. Dr. Castle’s ABG test produced resting PCO2 values of 36.7 and PO2 values of 68.7. (EX 4). Dr. Castle could not obtain exercise values. Neither of these tests produced qualifying values under Part 718, Appendix C. Again, that finding is of limited significance.

### **Treatment Records**

Claimant submitted three groups of medical records. First, Claimant submitted Miner’s treatment records from Johnston Memorial Hospital (“JMH”). (DX 11). These records span from February 05, 1998, to July 06, 2003. *Id.* Claimant also submitted Miner’s treatment records from Dr. Emory Robinette covering February 04, 1998, to July 06, 2003. (DX 10). Both of these records contain Miner’s autopsy report performed by Dr. David R. Hudgens on May 31, 2003. (DX 11, DX 10, DX 8). They also include the results of CT scans. (DX 11, DX 10). Finally, Claimant submitted Miner’s death certificate (reflecting his death on May 31, 2003) issued by Dr. Robinette on June 8, 2003 and filed on June 12, 2003. (DX 9).

As part of its case-in-chief, Employer submitted Miner’s treatment records from Norton Community Hospital (“NPH”), for treatment from December 18, 1997, to December 28, 1997. (EX 2). Additionally, Employer submitted Miner’s treatment records from JMH covering February 10, 1998, to February 13, 1998. (EX 3).

### **Autopsy and Biopsy Reports**

Employer submitted records from JMH, which entail the results of the biopsy performed on Miner in 1998. (EX 3). Additionally, Employer also submitted the February 4th, 2000, medical report of Dr. Richard L. Naeye, M.D., which was based on his examination of Miner’s biopsy slides. (EX 15).

An autopsy report by Dr. David Hudgens, the prosecutor, was prepared on June 3, 2003, and submitted by Claimant, who also submitted a report by Dr. Joshua Perper, M.D. that interpreted the autopsy and biopsy slides and addressed other matters, as discussed below. (DX 8; CX 3). In response, Employer submitted two reports from Dr. Naeye concerning Miner’s autopsy. The first, dated March 10, 2005, was submitted as part of its case-in-chief. (EX 6). Dr. Naeye’s second report, dated August 24, 2005, was submitted to rehabilitate his March 10th report in response to a report submitted by Claimant’s expert, Dr. Perper. (EX 8). Both of Dr. Naeye’s reports stated that Miner did not have pneumoconiosis at the time of his death, and that his death was not a result of the same. (EX 6, EX 8).

### **Medical Opinions**

Three physician opinions were offered regarding Miner’s cause of death and whether he suffered from coal worker’s pneumoconiosis. Two physicians believed Miner’s death was not caused by pneumoconiosis; one did.

(1) Dr. Joshua Perper, M.D., produced a report dated July 13, 2005, setting forth his opinion regarding Miner's cause of death. Dr. Perper is board-certified in anatomical, surgical, and forensic pathology. (CX 3). Dr. Perper's took into account numerous documents, some of which are not actually part of the record, in reaching his conclusion. Additionally, Dr. Perper reviewed the slides of Miner's lung tissue taken from his biopsy and autopsy. *Id.*

After examining the information provided to him, Dr. Perper reached several conclusions, which he stated in his report. First, Dr. Perper concluded that Miner suffered from coal workers' pneumoconiosis, which was caused by his exposure to coal dust during his employment. (CX 3). Second, he determined that the emphysema found in Miner's lungs was caused by pneumoconiosis. *Id.* Finally, Dr. Perper concluded that pneumoconiosis was the primary cause of Miner's death and was also a hastening factor of his death. *Id.*

(2) Dr. James Castle, M.D., offered two reports based on his examinations of Miner. Dr. Castle first report was produced on June 14, 2004, after he examined Miner while he still alive (EX 4); Dr. Castle's second report was produced on September 8, 2005 after Miner's death (EX 11).<sup>7</sup> Additionally, Dr. Castle's deposition was taken on September 16, 2005. Dr. Castle is board-certified in internal medicine and in the subspecialty of pulmonary diseases. (EX 12 at 5). He is also a B-reader. *Id.* at 6.

Dr. Castle's first report was made on September 8, 2000, and was made after he examined Miner, who was then alive. (EX 4). Dr. Castle received Miner's work history, and determined that he had worked long enough to be at risk for coal workers' pneumoconiosis. (EX 12 at 10). He also learned that Miner had breathing problems. *Id.* at 11. Dr. Castle also took an x-ray containing abnormalities and a 1/1 opacity profusion. (EX 4). Dr. Castle ultimately concluded that Miner did not have coal workers' pneumoconiosis, and his x-ray was consistent with usual interstitial pneumonitis or idiopathic pulmonary fibrosis causing mild restrictive lung disease. (EX 12 at 16).

After Miner's death, Dr. Castle produced a second report on September 8, 2005. (DX 11). Dr. Castle reviewed Miner's autopsy and the reports of Drs. Perper and Naeye. *Id.* Dr. Castle did not review the actual slides of Miner's lung tissue. After reviewing this information, Dr. Castle concluded that Miner still did not have coal workers' pneumoconiosis at the time of his death. (DX 11; EX 12 at 19). He further opined that Miner's death was the result of usual interstitial pneumonitis, which was not caused by coal dust exposure. (DX 11; EX 12 at 25). Finally, he concluded that coal workers' pneumoconiosis and coal dust exposure did not substantially contribute or hasten Miner's death. (DX 11; EX 12 at 25).

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<sup>7</sup> Although admitting both reports would arguably cause Employer to exceed evidentiary limitations on admissions of medical opinions into evidence, I believe that good cause has been established to admit both into evidence. *See* 20 C.F.R. §725.456(b)(1) (permitting admission of evidence exceeding evidentiary limitations for "good cause"). Because Dr. Castle performed an extensive examination of Miner in 2000, he would have enough familiarity with Miner to make a second opinion in 2005 based on his 2000 opinion. Essentially, the two reports are intertwined as they revolve largely around the same information. Additionally, Claimant is not harmed by the admission of both reports since her only expert that reviewed physician reports, Dr. Perper, reviewed both reports. (CX 3).

(3) Dr. Gregory J. Fino, M.D., prepared a report on behalf of Employer dated September 8, 2005, and also gave a deposition on September 27, 2005. (EX 9). Dr. Fino is board-certified in internal medicine and pulmonary diseases. (EX 14 at 4-5). He is also a B-reader. *Id.* at 5.

Dr. Fino reviewed several documents, including Miner's autopsy information. (EX 9). However, he did not actually review the slides; indeed, he testified that he was not capable of doing so. (EX 14 at 17). After reviewing the information, Dr. Fino conceded that from a pathological standpoint, simple coal workers' pneumoconiosis was present. *Id.* at 18. Despite the presence of pneumoconiosis, Dr. Fino opined that Miner's death was the result of usual interstitial pneumonitis and was in no way related to pneumoconiosis or coal dust exposure. *Id.* at 18-19. Dr. Fino concluded that even had Miner never worked in coal mines, he would have died in the same manner at the same time. *Id.* at 19. Dr. Fino's conclusion was based on Miner's degeneration of health in 1997-1998 and his absence of coal workers' pneumoconiosis at the same time. (EX 9; EX 14 at 17).

## **DISCUSSION AND ANALYSIS**

### **Evidentiary Limitations**

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), citing 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id.*, citing 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id.*, citing 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id.*, citing 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.*, citing 20 C.F.R. §725.456(b)(1).

The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra*. First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered “other medical evidence.” *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant’s medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5.

In *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-\_\_\_, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc), the Board changed the position that it took in *Dempsey* with respect to CT scan evidence and adopted the Director’s position that “the use of singular phrasing in 20 C.F.R. § 718.107” requires “only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence.”

As the Board noted in *Dempsey*, the regulations specifically allow evidence from a prior claim to be considered in connection with a later claim, so that a determination may be made whether there has been a material change in conditions since the time of the prior claim. 20 C.F.R. §725.309(d)(1). However, there is no such provision applicable to survivor’s claims that would allow consideration of the evidence developed in the miner’s claims, absent a finding of good cause. Consistent with the above limitations and the Board’s decision in *Dempsey*, other administrative law judges have generally excluded evidence developed in connection with a miner’s claim from consideration in a surviving spouse’s claim to the extent that the limitations have been exceeded, unless the case involves a consolidated miner’s claim and survivor’s claim.

In the instant case, evidence from the prior claim filed by the Miner was transmitted in a separate volume with the notation “Prior LM Claim Not to be admitted as evidence.” The parties were provided with a copy of that volume so that they could designate evidence from it, consistent with the evidentiary limitations. That volume has not been marked as an exhibit and does not warrant further discussion.

### **Medical Issues**

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the “true doubt” rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.



In order to prevail in a survivor's claim, a claimant must establish that the miner had pneumoconiosis arising out of his coal mine employment which caused, contributed to, or hastened his death. 20 C.F.R. §718.205.

If complicated pneumoconiosis is established, all of the above elements of a claim are presumptively established under the irrebuttable presumption set forth in 30 U.S.C. § 921(c)(3) and 20 C.F.R. §718.304. Claimant has submitted evidence that suggests that Miner may have suffered from complicated pneumoconiosis. Therefore, I must begin by determining whether Claimant has established Miner had complicated pneumoconiosis.

### ***Complicated Pneumoconiosis***

If a claimant can establish complicated pneumoconiosis (also known as "massive pulmonary fibrosis"), under the criteria set forth in 30 U.S.C. § 921(c)(3) and 20 C.F.R. §718.304, she is entitled to an irrebuttable presumption of death due to pneumoconiosis. *See generally Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976)(upholding constitutionality of presumption). Pursuant to §718.304, a claimant may be entitled to the irrebuttable presumption of death due to pneumoconiosis, under paragraph (a), based upon a chest x-ray finding of one or more large opacities (*i.e.*, greater than 1 centimeter in diameter) which would be classified as Category A, B, or C under the applicable classification requirements (such as ILO and UICC); under paragraph (b), based upon a biopsy or autopsy yielding "massive lesions in the lung"; or, under paragraph (c), based upon a condition which "when diagnosed by means other than those specified in paragraphs (a) and (b) . . . could reasonably be expected to yield the results described in paragraph (a) or (b) . . . had diagnosis been made as therein described: *provided, however*, that any diagnosis made under this paragraph shall accord with acceptable medical procedures." 20 C.F.R. §718.304.<sup>8</sup>

These clauses are intended to describe a single, objective condition, and subsection (a) provides an objective standard against which the other subsections can be measured. *See Eastern Associated Coal Corporation v. Director, OWCP [Scarbro]*, 220 F.3d 250, 255-57 (4th Cir. 2000). The statutory definition of complicated pneumoconiosis need not be congruent with a medical or pathological diagnosis. *Id.* at 257. *See also Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999) (declining to adopt blanket 2 centimeter rule for pathology findings and instead requiring an equivalency determination to be made); *Handy v. Director, OWCP*, 16 B.L.R. 1-73 (1990) (finding that an x-ray report indicating the absence of small or large opacities consistent with pneumoconiosis, but noting the presence of a 1.0 centimeter lesion in the right lung, was legally insufficient to establish the existence of complicated pneumoconiosis because section 718.304(a) requires a finding of one or more large opacities greater than one centimeter in diameter.) An equivalency determination must be made regardless of whether there is x-ray or pathological evidence of record. *Braenovich v. Cannelton Industries, Inc.*, 22 B.L.R. 1-237 (2003). In *Braenovich*, the Board upheld the administrative law judge's finding of complicated pneumoconiosis based upon his equivalency determination that a 1.5 centimeter lesion on autopsy would produce an opacity of equivalent size on x-ray even though he found both the x-

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<sup>8</sup> Both the statute and the regulations implementing the statute employ virtually the same language. *See* 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

ray evidence and the autopsy evidence to be insufficient to establish complicated pneumoconiosis, because “[e]vidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict.”<sup>9</sup> *Id.*, citing *Scarbro*.

While the section does not specifically require that a diagnosis of pneumoconiosis be associated with the lesions found, that requirement has been read into the regulation by the Benefits Review Board. In *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*), the Board stated that, because section 718.304 offered no opportunity for rebuttal, failure by an administrative law judge to consider all relevant evidence at the invocation stage could constitute a violation of an opposing party’s due process rights. The Board held that:

... the administrative law judge shall first determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh together the evidence at subsections (a), (b) and (c) before determining whether invocation of the irrebuttable presumption pursuant to Section 718.304 has been established.

The Board noted that CT scans fit under subsection (c). *Id.* In *Braenovich, supra*, the Board indicated that under the Fourth Circuit’s mandate in *Blankenship, supra*, “the administrative law judge is bound to perform equivalency determinations to make certain that, regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption.”

The Fourth Circuit has stated that evidence showing the existence of complicated pneumoconiosis loses its force only if other evidence affirmatively disproves it. *Eastern Associated Coal Corp. v. Director, Office of Workers’ Compensation Programs (Scarbro)*, 220 F.3d 250, 256 (4th Cir. 2000). In a recent unpublished decision, the Fourth Circuit clarified this position to emphasize that the burden is not on the employer to disprove complicated pneumoconiosis. *Clinchfield Coal Co. v. Director, Office of Workers’ Compensation Programs (Lambert)*, 2006WL3344010, slip op. at 2 (4th Cir. 2006).

It is in the context of this precedent that I will consider the evidence of record under section 718.304.

**Subsection (a): X-ray evidence.** Five readings of three x-rays were submitted as part of the current claim. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. When reports conflict, as they do here, I am required to weigh the qualifications of the experts involved. *Id.* Additionally, x-ray evidence can also be used to establish the existence of complicated pneumoconiosis if it reveals opacities greater than 1

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<sup>9</sup> The majority of the Board in *Braenovich* determined that the administrative law judge’s determination properly fit under subsection (c) of section 718.304 but the dissent maintained that it should have been considered autopsy or biopsy evidence under subsection (b). Thus, neither the majority nor the dissent applied the *Melnick* requirement of weighing the evidence under all three paragraphs together. The conflict arose in view of the assertion by some of the experts that there is a two-centimeter requirement for a pathological diagnosis of pneumoconiosis whereas there was also evidence that lesions on biopsy would result in approximately equivalent opacities on x-ray.

centimeter in diameter. 20 C.F.R. §718.304(a). In the instant claim, four of the five physicians who submitted readings are both board-certified in radiology and B-readers.

Dr. James Castle, who is a B-reader, but not board-certified in radiology, performed a reading of an x-ray he took of Miner on September 28, 2000. (EX 4). Dr. Castle found an opacity profusion of 1/1 and parenchymal abnormalities consistent with pneumoconiosis. *Id.* Dr. Castle opined that the markings found in claimant's lungs were consistent with interstitial pneumonitis, and not coal workers' pneumoconiosis. *Id.* He did not find any large opacities. (EX 4).

A second x-ray of Miner was taken on August 24, 1998, by Dr. Kathleen DePonte, a B-reader who is also board-certified in radiology. (CX 1). The x-ray was subsequently reread by Dr. William W. Scott, Jr., who is also a B-reader and board-certified in radiology. (EX 16). Dr. DePonte gave a 1/1 profusion and found a large type A opacity in Miner's right mid lung field. (CX 1). Dr. DePonte stated that it was unlikely that the large opacity was carcinogenic and ultimately found the x-ray showed pneumoconiosis with aggressive massive fibrosis. *Id.* Rereading the x-ray, Dr. Scott gave Miner a 1/1 profusion, but did not label a finding of any large opacities. (EX 16). Dr. Scott further opined that the profusion was most likely due to healed tuberculosis rather than coal workers' pneumoconiosis. *Id.* He also noted an area of focal fibrosis in miner's right mid lung. *Id.*

Dr. DePonte took a third x-ray of Miner on February 08, 2002. (CX 2). This one was subsequently reread by Dr. Paul Wheeler, who is a B-reader and board-certified in radiology. (EX 17). In this reading, Dr. DePonte once again found a large type A opacity in Miner's right lung; however, this time she gave a profusion rating of 2/1. (CX 2). Dr. DePonte believed her findings were consistent with pneumoconiosis. *Id.* Dr. Wheeler gave a 0/0 profusion and made no mention of a large opacity. *Id.* Furthermore, he stated that the "few tiny nodules" he found were consistent with healed granulomatous disease, tuberculosis, or histoplasmosis. *Id.*

Of the above x-ray readings, only two found the presence of a large opacity; and both were done by Dr. DePonte. By contrast, all three readings submitted by Employer made no mention of a large opacity. I first turn to Dr. Castle's reading conducted on September 28, 2000. Given that the other readings in this case were done by more qualified physicians, i.e., physicians who are also board-certified in radiology, I accredit those readings greater weight than Dr. Castle's. *See* 20 C.F.R. §718.202(a)(1). Therefore, I do not believe that Dr. Castle's reading disproves the existence of complicated pneumoconiosis.

Having determined Dr. Castle's reading should be accorded less weight, I am left with four readings by equally qualified physicians: two showing complicated pneumoconiosis, two not. I first turn to Dr. Paul Wheeler's reading of Dr. DePonte's February 08, 2002, x-ray. Of the four readings rendered by equally qualified physicians, Dr. Wheeler was the only one not to find any opacity profusion. This stands in stark contrast to Dr. DePonte's interpretation of the x-ray, who not only found a 2/1 profusion, but also found a large opacity. Even Dr. Castle, who is less qualified than the physicians who performed these four readings, found some profusion of opacities in his x-ray of Miner. Given that three readings of equally qualified physicians (and one reading of a less qualified physician) found an opacity profusion, I cannot say that Dr.

Wheeler's reading should be attributed more weight than the other three opinions rendered by equally qualified physicians.

I next turn to Dr. DePonte's x-ray of August 24, 1998, which was subsequently reread by Dr. William Scott. Although both doctors found a profusion consistent with evidence of pneumoconiosis, only Dr. DePonte attributed it to pneumoconiosis. By contrast, Dr. Scott attributed the profusion to healed tuberculosis. Since I have decided the readings of Drs. Castle and Wheeler should be attributed less weight than the readings of Drs. DePonte and Scott, I am left with three readings by equally qualified physicians. Of these three readings, two are positive for the presence of some form of pneumoconiosis. In other words, of the most qualified physicians whose opinions are attributed similar weight, the majority found the presence of pneumoconiosis. Therefore, I find that the x-ray evidence establishes the existence of pneumoconiosis. Since the majority of the x-ray evidence establishing pneumoconiosis shows the existence of complicated pneumoconiosis, I find the preponderance of x-ray evidence establishes the presence of complicated pneumoconiosis. However, I must still weigh this evidence with all the other evidence submitted on the issue of complicated pneumoconiosis.

**Subsection (b): Autopsy and Biopsy Evidence.** Under 20 C.F.R. §718.304(b), complicated pneumoconiosis may be proved through autopsy or biopsy evidence showing "massive lesions" in the lung. Both a biopsy and an autopsy were performed on Miner.

Miner had a biopsy performed on him on February 10, 1998, at Johnston Memorial Hospital; the records transmitted include the discharge summary by attending physician Emory H. Robinette, M.D.; the Operative Note by surgeon James Denton, M.D.; and the Surgical Pathology Report by pathologist David R. Hudgens, M.D.<sup>10</sup> (DX 10, 11; EX 3). Two pieces of lung tissue from the lingula and left lower lobe were removed and examined. *Id.* According to the Operative Note by Dr. Denton, a piece of the lung tissue was obtained for tuberculin, fungal and routine culture and the remaining specimen was sent to Dr. Hudgens who looked at it under frozen section and "felt that it was far advanced severe pulmonary fibrosis and that it might be difficult to make a diagnosis as to the etiology of the disease," resulting in the second section being taken. *Id.* Examining the tissues, Dr. Hudgens noted in the Surgical Pathology Report the presence of interstitial pulmonary fibrosis of the usual interstitial pneumonitis type. *Id.* No specific mention of pneumoconiosis or anthracosis was made in the biopsy report, but the discharge summary noted that "the photographs of the lung tissue did have evidence of anthracosis." *Id.* Miner was discharged on February 13, 1998. *Id.* Miner had no other biopsies performed on him.

Dr. Richard Naeye examined the results of Miner's biopsy and produced a report on February 4, 2000.<sup>11</sup> (EX 15). Based on the biopsy results, Dr. Naeye concluded that Miner was not suffering from pneumoconiosis at the time of his biopsy. *Id.* Specifically, he stated that while anthracotic pigment was present, there were no tiny birefringent crystals or rims of focal emphysema associated with it. *Id.*

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<sup>10</sup> The discharge summary is discussed below.

<sup>11</sup> Dr. Naeye incorrectly stated that the biopsy was of the right lung. (EX 15). All of the tissue that was biopsied was taken from the left lung. (EX 3).

In addition to preparing a medical report discussing the medical evidence in toto, discussed below, Dr. Joshua Perper, a pathologist, reviewed the slides of Miner's lung tissue taken from his biopsy and autopsy on behalf of the Claimant. Based upon the biopsy slides, he found "[d]iffuse interstitial fibrosis secondary to exposure to mixed coal dust containing silica, with scattered small anthracotic deposits and birefringent silica crystals." (CX 3 at 37.)

Miner died on May 31, 2003. (DX 9). Dr. Hudgens performed an autopsy on him on the same date and reported the results on June 3, 2003. (DX 10). Dr. Hudgens conducted an external and internal examination; he also conducted a microscopic and a macroscopic investigation. *Id.* In doing a macroscopic examination of the lungs, Dr. Hudgens found numerous, small, foci of anthracotic pigment, each approximately 3-4 mm in diameter. *Id.* He also found "palpable nodules on the pleural surfaces and the cut surfaces" approximately 2 mm in diameter. *Id.*

Dr. Hudgens' microscopic examination also uncovered several findings. He found anthracotic macules and silicotic nodules with surrounding accumulations of black pigment. (DX 10). He also found a diffuse fibrotic process unrelated to the pigment with varying degrees of fibrosis. *Id.* Additionally, he found emphysema around the nodules. *Id.* Dr. Hudgens' final pathological diagnosis was as follows:

1. Simple coal workers' pneumoconiosis.
2. Usual interstitial pneumonitis.
3. Cardiac hypertrophy and dilation consistent with congestive heart failure.
4. Severe coronary atherosclerosis.

*Id.*

Based upon his review of the autopsy slides, Dr. Perper made the following microscopic diagnoses:

1. Interstitial type of coal workers pneumoconiosis, macular, micronodular and macronodular with interstitial fibrosis secondary to exposure to mixed coal dust containing silica.
2. Coronary arteriosclerosis, moderate severity.

(*Id.* at 39.)

Dr. Richard Naeye produced two reports on behalf of Employer after Miner's death. Dr. Naeye's first report was dated March 10, 2005; his second report was made after Dr. Perper's report and was dated August 24, 2005. (EX 6, EX 8). He also gave a deposition on September 19, 2005. (EX 13). Dr. Naeye is board-certified in anatomic and surgical pathology, but not forensic pathology. (EX 13 at 58).

In his first report, Dr. Naeye concluded that Miner did not suffer from pneumoconiosis, nor was his death a result of the same. (EX 6). Of particular importance to Dr. Naeye was his

determination that the slides he reviewed did not show the presence of “many toxic silica crystals” which he said was normally found in the lungs of those with coal workers’ pneumoconiosis (or at least those he examined). *Id.* Dr. Naeye did state he found one “rare birefringent crystal”, but it was “too large” to be toxic. *Id.* Additionally, while he found lesions in Miner’s lungs, he said they were not of the variety normally associated with coal workers’ pneumoconiosis. *Id.*

Dr. Naeye’s second report was produced in response to Dr. Perper’s report, which challenged the findings of Dr. Naeye’s March 10th report. (EX 8). In addition to reviewing Dr. Perper’s report, he also re-reviewed the same autopsy slides he examined when preparing his previous report. *Id.* Dr. Naeye reiterated that a person suffering from coal workers’ pneumoconiosis would have tiny particles of silica in their lungs. *Id.* However, Dr. Naeye for the first time mentions that Miner did indeed have “[b]irefringent silicotic particles” present in his lung, but too few existed to cause coal workers’ pneumoconiosis. *Id.* Dr. Naeye once again stated that Miner did not have pneumoconiosis, and he did not die from it either. *Id.*

In examining autopsy evidence when complicated pneumoconiosis may be present, I am required to perform an equivalency determination. *See Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999). I must ascertain whether the autopsy evidence demonstrating nodules in the lung sufficiently corresponds with the presence of an opacity greater than 1 centimeter in diameter on the x-rays submitted into evidence. *Id.*

None of the pathologists mentions a nodule of the requisite size. Dr. Hudgens’ report lists nodules that are 2 millimeters in diameter. (DX 10). Nowhere in his report does he mention the presence of nodules that are greater than 1 centimeter in diameter nor does he mention that any nodules would appear as greater than 1 centimeter in diameter on x-rays. Aside from Dr. Hudgens, two other pathologists, Drs. Richard Naeye and Joshua Perper, examined slides of lung tissue taken from Miner’s autopsy. Dr. Perper found 7 millimeter and 5 millimeter nodules, but none that measured any greater or would appear greater on x-rays. (CX 3). Dr. Naeye made no mention of taking his own measurements other than to quote Dr. Hudgens’ report. (EX 6). None of the evidence in the record mentions any nodules greater than 1 centimeter in diameter or provides a basis for an equivalency determination. Therefore, I do not believe the autopsy evidence sufficiently establishes the presence of complicated pneumoconiosis.

I next address the biopsy evidence. The biopsy was conducted several years before Miner’s death, and made no mention of nodules. Indeed, it made no mention of pneumoconiosis whatsoever. No specific nodules were identified in the biopsy slides by Drs. Naeye or Perper either. However, I believe the biopsy test results are entitled to less weight since it was conducted well before Miner’s death and his subsequent autopsy. *See* 20 C.F.R. 718.201(c) (stating that pneumoconiosis is recognized as a latent and progressive disease). It also only concerned the left lung, from which a wedge was removed from the lower portion.<sup>12</sup> Nevertheless, since the necessary nodules are not present in the autopsy evidence, my attributing less weight to the biopsy report does not change my conclusion that the autopsy evidence does

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<sup>12</sup> The coalescence found in contemporaneous CT scans of February 5, 1998, interpreted as “probably representing silicosis with progressive massive fibrosis,” was in the upper right lobe. (DX 10).

not demonstrate the complicated pneumoconiosis. In summation, I find that neither the biopsy or autopsy evidence sufficiently establishes complicated pneumoconiosis.

**Subsection (c): Other Evidence.** Several items constituting other evidence were submitted. The medical opinions of Drs. Joshua Perper, James Castle, and Gregory Fino were offered. Additionally, medical records, including the death certificate and CT scans, were offered.

(1) **Medical Opinions.** As noted above, medical opinions were offered by Drs. Perper, Castle, and Fino. None of these physicians found that Miner suffered from complicated pneumoconiosis. As discussed above, of these three, only Dr. Castle continues to maintain that the Miner did not have simple pneumoconiosis.

(2) **CT Scans.** Reports of CT scans appear in the JMH hospital records and in Dr. Robinette's records. (DX 10, 11).

The CT scan of the thorax performed on February 5, 1998 was interpreted by J. Richard Mullens, M.D., as showing the following:

1. Nodular interstitial lung disease with coalescence in the RUL probably representing silicosis with progressive massive fibrosis.
2. Interstitial lung disease predominately involving the lung bases.

(DX 10). Thus, the February 1998 CT scan found silicosis and progressive massive fibrosis in the right upper lobe, although it also found a concurrent problem in the lung bases. However, it did not indicate the size of the lesions in the right upper lobe or how they would appear on x-rays. Although it supports a finding of progressive massive fibrosis, or complicated pneumoconiosis, it does not satisfy the *Melnick* criteria.

CT scans were also taken on September 23, 2002 and October 8, 2002. (DX 11). The first was interpreted by Dr. Mullens as showing "[c]hronic interstitial lung disease with extensive bilateral ground glass opacities" which were not specific but "could represent an active phase of interstitial pneumonitis such as DIP." *Id.* On the CT scan of October 8, 2002, Dr. Mullens found "[s]evere end state interstitial lung disease with probable superimposed active component manifest by ground glass opacities" with "little change" from September 23, 2002. *Id.* These interpretations do not support a finding of complicated pneumoconiosis.

(3) **Death Certificate.** Miner's death certificate, signed by Dr. Emory Robinette on June 8, 2003, mentions pneumoconiosis as a cause of Miner's respiratory failure and death on May 31, 2003. (DX 9). However, there is no mention of complicated pneumoconiosis or progressive massive fibrosis.

(4) **Treatment and Hospital Records.** In addition to the above, there are treatment records from Dr. Emory Robinette (DX 10); records from Johnston Memorial Hospital ("JMH") (DX 11); and records from Norton Community Hospital ("NCH") (EX 2).

Dr. Emory Robinette, M.D., examined Miner on several occasions from 1998 through 2003. (DX 10). The records show that Miner was hospitalized at NCH in December 1997 after three weeks in which he experienced increasing difficulty with breathing. (EX 2). On February 4, 1998, Dr. Robinette examined Miner and found progressive pulmonary fibrosis and coal workers' pneumoconiosis. *Id.* A subsequent CT Scan with IV contrast and high resolution, discussed above, was performed the following day at Dr. Robinette's request. *Id.* Claimant was hospitalized at NCH from February 10 to 13, 1998. It was during the hospitalization that the biopsy, discussed above, was performed. *Id.* The diagnosis upon discharge was as follows:

1. Usual interstitial pneumonitis.
2. Chest wall pain with underlying obstructive pulmonary disease.
3. Hypertensive cardiovascular disease.
4. Gouty arthritis.
5. History of bladder carcinoma treated with BCG instillation.

*Id.*

After the biopsy was performed, Dr. Robinette diagnosed Miner with usual interstitial pneumonitis, but not pneumoconiosis. (DX 10). However, he later clarified in a letter dated September 28, 1998, that Miner had a history of coal dust exposure with radiographic changes consistent with coal workers' pneumoconiosis. *Id.* In December 1999, Dr. Robinette issued a report to Miner's counsel stating that Miner was suffering from coal workers' pneumoconiosis with associated interstitial pulmonary fibrosis. *Id.* Dr. Robinette examined Miner on several follow up visits through 2002, but noted no substantial change in Miner's condition. *Id.*

Miner was admitted into JMH in 2002 because of severe dyspnea. *Id.* In addition to congestive heart failure, Dr. Robinette once again diagnosed coal workers' pneumoconiosis with usual interstitial pneumonitis. *Id.* Claimant was once again admitted in October 2002, with Dr. Robinette reaching the same conclusions as before, but found that his dyspnea had worsened. *Id.* He was once again admitted May 2003 with clinical respiratory failure associated with cor pulmonale and pulmonary fibrosis. *Id.* Miner died on May 31, 2003. *Id.* Dr. Robinette listed the following diagnoses at the time of his death:

1. Respiratory failure secondary to methicillin-resistant *Staphylococcus aureus* pneumonia and *Candida* pneumonia.
2. Pulmonary fibrosis with simple pneumoconiosis.
3. Congestive heart failure with components of cor pulmonale.
4. Diabetes mellitus.

*Id.* The last item contained in the JMH records was Dr. Hudgen's autopsy report, discussed above.

Additional records were obtained from Johnson Memorial Hospital. (DX 11). These records are in part duplicative of Dr. Robinette's records. However, they also contained additional pulmonary function studies and arterial-blood gas studies. *Id.*



Employer submitted treatment records from Norton Community Hospital relating to the December 18 to 28, 1997 admission, including a discharge summary from Dr. Anilkumar Joshi and a History and Physical from Dr. Gary Williams. (EX 2). Dr. Joshi examined Miner after he was admitted for shortness of breath in December 1997. *Id.* Dr. Joshi made the following diagnosis upon discharge:

1. Bilateral atypical pneumonia with respiratory failure.
2. Chronic obstructive pulmonary disease, chronic bronchitis.
3. Coal workers' pneumoconiosis.
4. Hypertension.
5. Benign PVC's.
6. CA of the bladder and gouty arthritis.

*Id.* Dr. Williams took Miner's history and his physical during his December 1997 admission. (EX 2). Dr. Williams reached the same conclusions as did Dr. Joshi with respect to diagnosis. *Id.*

Having examined all the "other evidence" submitted which could be considered in determining whether or not Miner suffered from complicated pneumoconiosis, I find that it does not establish the existence of complicated pneumoconiosis. With respect to the physician opinions, none of the physicians concluded that Miner suffered from complicated pneumoconiosis. Even the doctors who believed that Miner was suffering from some form of pneumoconiosis did not diagnosis him with the complicated variety. Given the lack of any information regarding complicated pneumoconiosis in the above category of information (aside from the February 1998 CT scan, which does not provide a basis for an equivalency determination), I find that the other evidence submitted does not demonstrate complicated pneumoconiosis.

**Section 718.304 as a whole.** Having reviewed each of the categories of evidence under Section 718.304, I now examine all three categories of evidence together. *See Melnick, infra.* As I discussed above, of the three categories of evidence examined concerning the existence of complicated pneumoconiosis, I found only one category, the x-ray evidence, positively showed its existence.

Despite my conclusion regarding the x-ray evidence, when all the other categories of evidence presented are examined, I find Claimant has not established Miner suffered from complicated pneumoconiosis. As my review of the autopsy information demonstrates, no nodules greater than 1 centimeter (or an equivalency determination to that effect) were found by any of the pathologists who reviewed the slides. Additionally, none of the "other evidence" submitted detailed any finding of complicated pneumoconiosis, apart from the single CT scan, which merely listed progressive massive fibrosis without assessing the size of the nodules; the later CT scans did not list such a diagnosis. Given this, I cannot say that Dr. DePonte's two x-ray readings sufficiently overcome all the evidence presented on the issue of complicated pneumoconiosis. Therefore, I find that Claimant has not proven by a preponderance of the evidence that Miner suffered from complicated pneumoconiosis. However, this does not end my

analysis as I must now determine whether Miner suffered from simple coal workers' pneumoconiosis.

### ***Simple Pneumoconiosis***

Having determined that Miner did not suffer from complicated pneumoconiosis, I now examine whether the evidence establishes that Miner suffered from simple pneumoconiosis. The regulations (both in their original form and as revised effective January 19, 2001) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. The United States Court of Appeals for the Fourth Circuit has held that all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.")

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

In the recent amendments to the regulations, the definition of pneumoconiosis in section 718.201 has been amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis, such as coal worker's pneumoconiosis or silicosis. Legal pneumoconiosis is defined as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b).

Because the evidence in this case on the issue of simple pneumoconiosis is the same evidence submitted on the issue of complicated pneumoconiosis, I will explore the evidence in further detail only when necessary.

**X-ray evidence.** As I discussed in greater detail *supra*, of the five readings submitted, only two were positive for pneumoconiosis, while three were negative. However, I accorded less weight to Dr. Castle's interpretation due to the fact he was not board-certified in radiology at the time of his reading. I also said that Dr. Wheeler's interpretations should be accorded less weight because of all the readings, his was the only one not to find any opacity profusion. Finally, I concluded that since two of the three remaining equally weighted opinions showed the presence of complicated pneumoconiosis, the x-ray evidence was positive for the presence of complicated pneumoconiosis. Likewise, these same two readings found the existence of simple pneumoconiosis. Despite the fact that I have decided Miner did not suffer from complicated pneumoconiosis, I do find that the x-ray evidence does demonstrate the existence of simple coal workers' pneumoconiosis for the reasons I have just listed. I am also persuaded by other evidence presented in this case as well.

Because this claim arose in the Fourth Circuit, it is appropriate for me to weigh all the evidence on the issue of pneumoconiosis together. *See Compton, infra*. This is particularly crucial in the instant case because of Miner's autopsy report and his medical treatment records.

Dr. Scott's reading of the August 24, 1998, x-ray stated that he believed the markings he found in Miner's lung were "most likely" due to healed tuberculosis, and not coal workers' pneumoconiosis. (EX 16). Likewise, Dr. Wheeler's reading of the February 8, 2002, x-ray stated the nodules he found in Miner's lungs were "compatible with healed granulomatous disease, [tuberculosis] or histoplasmosis." (EX 17). Despite the physicians' assertions of tuberculosis or other granulomatous disease, Miner's autopsy produced no evidence of its existence. (DX 10). This fact was noted by Dr. Perper as well. *See* (CX 3). Additionally, Miner's treatment records, which list his medical history at several locations, make no mention of the disease either. (DX 10, DX 11). Although I recognize that Employer does not have the burden of proving Miner had tuberculosis and not coal workers' pneumoconiosis, the assertions of these doctors lose credibility in light of the other evidence submitted. Therefore, I find it appropriate to attribute the readings of Drs. Wheeler and Scott even less weight.

Because I attribute substantially less weight to the readings conducted by the Employer's physicians for the reasons listed above, I find it appropriate to attribute greater weight to the readings conducted by Dr. DePonte. Therefore, I believe the x-ray evidence sufficiently establishes the existence of pneumoconiosis.

**Autopsy and Biopsy Evidence.** A claimant may prove the existence of pneumoconiosis through autopsy or biopsy evidence. 20 C.F.R. §718.202(a)(2). The regulation makes clear that the mere presence of anthracotic pigmentation in itself is not enough to establish pneumoconiosis. *Id.*; *see also Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001) (en banc). The autopsy and biopsy evidence are discussed in greater detail *supra*.

In Dr. Hudgens' autopsy report, he detailed finding "foci of anthracotic pigment" during his examination of Miner's lungs. (DX 10). Upon conducting a microscopic examination, Dr. Hudgens found "anthracotic macules and silicotic nodules with surrounding accumulations of black pigment." *Id.* He also found emphysema around the nodules, and a diffuse fibrotic

process unassociated with the pigment. *Id.* Ultimately, under pathological findings, Dr. Hudgens listed a finding of simple coal workers' pneumoconiosis. *Id.*

I next turn to Dr. Naeye's reports. I first note that Dr. Naeye is not board-certified in forensic pathology, although he is board-certified in anatomical and surgical pathology. (EX 13 at 58). By contrast, Dr. Perper is board-certified in all three. (CX 3). I therefore attribute less weight to Dr. Naeye's examinations because of Dr. Perper's superior qualifications. *See Helton v. P & R Coal, Inc.*, BRB No. 05-0374 BLA (Jan. 5, 2006) (per curiam) (unpub.); *see also Milburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998). I now address Dr. Naeye's reports themselves.

In the two reports prepared by Dr. Naeye in 2005 after Miner's death he does not thoroughly list out all the records he reviewed in reaching his final conclusion regarding Miner's death. (EX 13 at 50). This is particularly troubling given Dr. Naeye's testimony that in "99.9%" of his reports he lists all the information he reviewed in preparing an opinion. *Id.* Specifically, he stated that he lists "every single document that [he] read, every word." *Id.* Yet somewhat confusingly, Dr. Naeye testified that he does not include information in his report about other evidence he examined if he felt it did not contribute towards the diagnosis. (EX 13 at 49). This was particularly noticeable in one instance where he claimed to have studied notes made by Dr. Robinette, but made no mention of them in his report. *Id.* at 47-49.<sup>13</sup> Given such statements, it is difficult for me to ascertain fully what he did and did not consult in preparing his opinion. As such, I further attribute less weight to his findings.

I now turn to Dr. Naeye's diagnosis itself. In both 2005 reports, Dr. Naeye found that Miner was not suffering from coal worker's pneumoconiosis at the time of his death. (EX 6, EX 8). He believed Miner's death was caused by fibrotic lesions found in his lungs, but that they were not occupationally related. (EX 6). As discussed *infra*, in his first report Dr. Naeye noted that the absence of "many" toxic silica crystals led him to believe Miner did not have pneumoconiosis, because such crystals would invariably be found in the lungs of those suffering from pneumoconiosis. (EX 6). However, he did state he found one large "birefringent" crystal, but it was "too large" to be toxic. *Id.* In his next report, Dr. Naeye stated he did indeed find small crystals, but too few existed to demonstrate pneumoconiosis was present. (EX 8). Nowhere does he state how many crystals must be present and what size they must be before pneumoconiosis can actually be found. Although I once again reiterate that Employer does not have the burden of disproving pneumoconiosis, I find Dr. Naeye's requirements for a finding of pneumoconiosis to be too vague and equivocal to accredit substantial weight to. Moreover, Dr. Naeye has not adequately explained why he changed his findings between the two reports.

Dr. Naeye's discussion concerning the microscopic findings produced from Miner's autopsy is also lacking. In his 2000 biopsy examination, Dr. Naeye stated Miner did not have pneumoconiosis because the aforementioned crystals were not present, and because there were no "rims of focal emphysema" around the anthracotic pigment found in his lungs. (EX 15). In

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<sup>13</sup> Indeed, in his 2000 biopsy report, Dr. Naeye stated he "received for review a large volume of medical records from Johnston Memorial Hospital and Drs. Robinette, Forehand, Mullens, DePonte, Gopalan, Haines, Joshi, and Denton." (EX 15). From this large category of information, Dr. Naeye does not state what specific documents he received and what, if anything, he reviewed from these records.

his autopsy report, Dr. Hudgens describes finding emphysema present around nodules surrounded by anthracotic pigment. (DX 10). Although Dr. Naeye goes to great lengths in his 2005 reports to mention that he could not find the presence of sufficient numbers of these crystals, he makes absolutely no mention of the emphysema found by Dr. Hudgens. This is particularly noticeable because Dr. Naeye wrote that he generally agreed with Dr. Hudgens' microscopic findings. (EX 6). Furthermore, Dr. Naeye testified that he could not entirely rule out the possibility that there was evidence of simple coal workers' pneumoconiosis in Claimant's lungs, although he could not find it. (EX 13 at 31). Because Dr. Naeye has offered no explanation for ignoring details he deemed necessary for a finding of pneumoconiosis, his findings are entitled to even less weight.

After reviewing all the autopsy evidence presented, I conclude that it supports a finding of simple coal worker's pneumoconiosis.

I next turn to Miner's biopsy, which was conducted in February 1998. (EX 3). Dr. Hudgens, who also performed Miner's biopsy and examined the lung tissue taken, made no mention of coal workers' pneumoconiosis. *Id.* Indeed, he diagnosed Miner with usual interstitial pneumonitis. Neither Dr. Naeye nor Dr. Perper found coal worker's pneumoconiosis on biopsy, although Dr. Perper attributed the diffuse interstitial fibrosis he found to Claimant's exposure to mixed coal dust containing silica ("legal pneumoconiosis"). (CX 3 at 37.) Although Miner's biopsy did not show evidence of coal workers' pneumoconiosis, I attribute greater weight to the autopsy because it was conducted five years later and directly after Miner's death, in view of the progressive nature of pneumoconiosis. *See* 20 C.F.R. §718.201(c).

**Complicated Pneumoconiosis and Other Presumptions.** As I discussed in much greater detail *supra*, Claimant has not established that Miner suffered from complicated pneumoconiosis; therefore, none of the associated irrebuttable presumptions regarding complicated pneumoconiosis apply. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable, *inter alia*, because they do not apply to claims filed after January 1, 1982, or June 30, 1982, respectively. Therefore, Claimant has not established pneumoconiosis through section 718.202(a)(3).

**Medical Opinions on Pneumoconiosis.** Three physicians offered opinions on whether Miner had pneumoconiosis at the time of his death. Dr. James R. Castle, M.D., a pulmonologist, found that Miner did not have pneumoconiosis and that his death was not hastened or due to pneumoconiosis. (EX 4, 6, 11, 12). Dr. Gregory J. Fino, M.D., also a pulmonologist, conceded that pneumoconiosis could have been present, but did not believe his death was a result of pneumoconiosis. (EX 9, 14). However, Dr. Perper, a pathologist who also reviewed the autopsy slides, found that claimant had pneumoconiosis which caused and hastened his death. (CX 3). I must consider how much weight to give to each physician opinion because they conflict.

I turn first to Dr. Castle, who did not believe Miner suffered from pneumoconiosis or that his death was caused by it. (EX 11; EX 12). Dr. Castle is not a pathologist, and as such, is not board-certified in any field of pathology. (EX 5). Consequentially, although Dr. Castle reviewed the autopsy and reports based on the autopsy, he never reviewed the slides of Miner's

lung tissue. Because other physicians reviewed autopsy slides while Dr. Castle did not, it is appropriate for me to accredit his findings less weight. See *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985); *Fetterman v. Director, OWCP*, 7 B.L.R. 1-688 (1985). Additionally, I attribute less weight to Dr. Castle's findings because his conclusion was based in part on his reading of the x-ray he took of Miner. (EX 4). However, as I stated above, I believe the x-ray evidence establishes the existence of pneumoconiosis. Since Dr. Castle's opinion is based partially on findings contrary to my own, I accredit his conclusion on the existence of pneumoconiosis less weight.

Dr. Fino conceded that pneumoconiosis was present. (EX 9). However, he did not do a full analysis like Dr. Perper. Indeed, his acceptance of pneumoconiosis found in Miner's lungs appear to be based mostly on the fact that Drs. Hudgens and Perper found it, rather than as a result of any examination conducted by himself. *Id.* As such, I cannot say that his finding of pneumoconiosis entitles his opinion to additional weight.

I next turn to Dr. Perper's opinion. Dr. Perper's report lists every piece of information he reviewed in preparing his report and conclusions. (CX 3). In preparing his report, Dr. Perper reviewed documents which are not part of the record, most of which were admitted as part of Miner's living claim. *Id.* Such documents are not properly part of the record in the instant claim, and cannot be considered in assessing Dr. Perper's opinion. However, he also reviewed the admitted medical evidence discussed *supra*. In particular, I believe Dr. Perper's report sufficiently establishes that his opinion is based largely upon his examination of Miner's lung tissue slides. *Id.* I do not believe that the inadmissible information Dr. Perper examined is so entwined with his report to disqualify the entire report. Nevertheless, I do not rely on his report with respect to any references it makes to inadmissible information. Furthermore, his findings are entitled to less weight to the extent that he has relied upon the inadmissible evidence.<sup>14</sup> However, I believe his findings should be attributed greater weight than Dr. Naeye's due to all the reasons listed above. I also believe his findings should be given greater weight than Dr. Castle's due to Dr. Perper's superior qualifications and the fact he actually reviewed the pathological evidence.

Turning to Dr. Perper's report, I find that it constitutes persuasive evidence supporting a diagnosis of simple coal workers' pneumoconiosis at the time of Miner's death. Dr. Perper used six grounds to determine Miner suffered from pneumoconiosis. (CX 3). Briefly summarized, Dr. Perper relied on: (1) the fact that Miner was a coal-miner for 21 years, (2) Miner had worsening chronic lung disease, (3) the presence of centrilobular emphysema in someone who did not smoke, (4) progressive respiratory deterioration, (5) the radiological presence of coal workers' pneumoconiosis, and (6) the pathology of Miner's lungs. *Id.*<sup>15</sup> Of particular importance to Dr. Perper was the pathological evidence, which he described as the "golden and ultimate yardstick for determining the presence of coal workers' pneumoconiosis." *Id.*

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<sup>14</sup> Some of the inadmissible evidence merely consists of the opinions of other physicians, such as Dr. Echols R. Hansbarger, with whom he disagreed. (CX 3). As he disagreed with him, it is clear that Dr. Perper did not rely upon Dr. Hansbarger's opinion.

<sup>15</sup> All six of these basis can easily be attributed to the evidence of record in the instant claim.

Like Dr. Hudgens, Dr. Perper found the presence of macules and nodules associated with pneumoconiosis. (CX 3). Dr. Naeye did not discuss these in either of his reports, choosing to instead focus on the perceived lack of sufficient birefringent crystals. As such, he offered no opinion on what, if any, effect these findings would have on his conclusion that Miner did not have pneumoconiosis. Additionally, Dr. Naeye did not discuss Dr. Hudgens' discovery of emphysema. As discussed *supra*, the evidence shows Miner was not a smoker. Despite this, Dr. Naeye offered no explanation where the emphysema could have come from.

Dr. Perper states in his report that Miner was suffering from a particular type of pneumoconiosis: interstitial coal workers' pneumoconiosis. (CX 3). According to Dr. Perper, this type of pneumoconiosis is "characterized by interstitial pulmonary fibrosis, mimicking diffuse interstitial fibrosis on a background of pneumoconiotic macules and nodules." *Id.* He further wrote that diffuse interstitial fibrosis can be present in the lungs of miners who have non-asbestos pneumoconiosis caused by occupational coal dust exposure. *Id.* In support of this contention, Dr. Perper cites several studies wherein pneumoconiosis sufferers suffered from diffuse interstitial fibrosis and pneumoconiosis, although no correlation is made between them. *Id.* Boiled down to its basics, Dr. Perper opined that Miner's exposure to coal dust led to his interstitial pneumonitis, which in turn led to his death. Dr. Fino cites to literature in his report that he claims disproves that something like this could occur. (EX 9). However, because the application of epidemiological evidence to pathological data is involved, I find that Dr. Perper's opinion is entitled to additional weight.

Although Dr. Perper does not expressly state as much, his report essentially diagnosed Miner with legal pneumoconiosis as well as clinical pneumoconiosis.<sup>16</sup> Dr. Perper concluded that Miner's exposure to coal dust led to interstitial pulmonary fibrosis that gave the appearance of diffuse interstitial fibrosis. (CX 3). As discussed above, legal pneumoconiosis is any chronic lung disease or impairment arising out of coal mine employment. 20 C.F.R. §718.201(a). A chronic lung disease arising from employment must be substantially aggravated by dust exposure during coal mine employment. 20 C.F.R. §718.201(b). Dr. Perper's opinion establishes that the disease Miner was suffering from at his death was a lung disease arising from coal mine employment.

After reviewing all the opinions in evidence, I find Dr. Perper's to be the most persuasive. I find the opinion of Dr. Perper more credible than the opinions presented by the other physicians rendering opinions in this matter. Not only is Dr. Perper more qualified, he actually examined the pathological evidence in this claim in order to reach his conclusions. Therefore, I believe the medical evidence in this case sufficiently establishes that Miner was suffering from pneumoconiosis.

**Other Evidence of Pneumoconiosis.** Other evidence in this matter submitted consists of Miner's medical records (including CT scans) and his death certificate. Both are described in greater detail *supra*.

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<sup>16</sup> Of course, a physician is not required to explicitly state that a miner was suffering from legal pneumoconiosis. See *Barber v. Director, OWCP*, 65 F.3d 1189 (4th Cir. 1995).

Central to the medical records submitted by Claimant were the notes of Dr. Emory Robinette. As stated above, Dr. Robinette examined Miner on several occasions between 1998 and 2003. (DX 10). At the time of Miner's death, Dr. Robinette listed pneumoconiosis as one of his diagnoses. *Id.* Dr. Robinette's diagnosis of pneumoconiosis seems to be based upon Miner's work history, radiographic evidence, and his biopsy results (and later his autopsy report). *Id.*

Turning to the evidence relied upon by Dr. Robinette, and first to Dr. Robinette's x-ray evidence, I note that several readings are submitted from Dr. Richard Mullens, and another reading by Dr. Kathleen DePonte. (DX 10). As these readings appear in the medical records, they do not need to comply with the evidentiary limitations, although they will not be considered as part of the x-ray evidence for the existence of pneumoconiosis. The CT scan evidence is equivocal, with the 1998 CT scan finding two forms of interstitial lung disease, one of which was likely silicosis, while the 2003 CT scans only mentioned interstitial lung disease without addressing its etiology. With respect to the biopsy, as I discussed above, it does not constitute positive evidence for the existence of pneumoconiosis. Finally, although Dr. Robinette received the information from Miner's autopsy he does not appear to have personally reviewed the slides himself. However, Dr. Robinette did examine Miner on several occasions and was in a good position to chronicle his condition; therefore, his notes are not entirely without weight, in view of his status as a treating physician who treated the Miner for his lung condition on multiple occasions over a five year period. *See* 20 C.F.R. §718.104(d).

I next examine Miner's death certificate, which was also prepared by Dr. Robinette. (DX 9). Initially, I note that the death certificate, signed by Dr. Robinette, states that the immediate cause of death was "Respiratory Failure [secondary to] Pneumonia" due to (or as a consequence of) "Pulmonary Fibrosis with CWP." (DX 9). Although the certificate was prepared by Dr. Robinette, who was already familiar with Miner's health, it does not lay out the basis for this determination. Thus, I cannot say the death certificate in itself is very probative on whether or not Miner had simple coal workers' pneumoconiosis at the time of his death, apart from constituting the opinion of his treating physician.

Taken together, the other evidence submitted on the issue of pneumoconiosis is slightly probative on Miner's condition at the time of his death. However, even were I to find that the treatment records and death certificate had no probative value whatsoever on the issue of pneumoconiosis, the other evidence submitted by Claimant clearly establishes the existence of pneumoconiosis.

**All evidence.** I find that all the evidence submitted on the issue of pneumoconiosis, considered together, establishes that Miner was suffering from simple coal workers' pneumoconiosis and legal pneumoconiosis at the time of his death. I therefore turn to the next step in my analysis.

### **Causal Relationship**

In order to recover in a survivor's claim for black lung benefits, Claimant must not only establish the existence of pneumoconiosis, she must also show that it arose from Miner's coal



mine employment. Under the governing regulations, if it has been established that a coal miner has pneumoconiosis and that he worked for ten or more years in coal mines, there is a rebuttable presumption that the disease arose from the employment. 20 C.F.R. §718.203(b). As the Miner clearly had more than ten years of coal mine employment, I find it appropriate to apply the aforementioned presumption.

In the instant claim, Director found that miner had established 19.22 years of coal mine employment, based upon Claimant's earnings. (DX 21; *see also* DX 5). Claimant also testified that Miner worked for 22 years, with some periods of layoffs. (Tr. 29). The Social Security earnings records establish 72 quarters of coal mine employment (18 years) between 1957 and 1976, and the Miner asserted additional employment in 1977 and 1978. (DX 4, 5). Given that the Director was able to examine Miner's social security earnings and take into account the additional asserted earnings, it is more appropriate to credit his findings over Claimant's testimony. I therefore find that Claimant has established that Miner worked for 19.22 years as a coal miner. Although Employer contested this number, it has provided no evidence to call the Director's calculations into question.

I also find that Employer provided no evidence which would rebut this presumption. Indeed, since Employer's evidence disputed that Miner even had pneumoconiosis, it did not address where it may have arisen from if he had contracted it. As such, I find that Claimant has established that Miner's pneumoconiosis arose from his coal mine employment.

### **Death due to Pneumoconiosis**

Apart from proving Miner suffered from pneumoconiosis that arose from his coal mine employment, Claimant must also prove Miner's death was due to pneumoconiosis in order to receive benefits.

Since this survivor's claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by 20 C.F.R. § 718.205(c). As amended, that subsection provides:

(c) For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 [relating to complicated pneumoconiosis] is applicable.

(4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

Twenty C.F.R. § 718.205(c) (2001). Subsection (5) was added when the regulations were amended. Under existing precedent in the Fourth Circuit (and elsewhere), consistent with new subsection (5), any condition that hastens a miner's death is a substantially contributing cause of death. *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. denied*, 506 U.S. 1050 (1993); *see also Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 757-62 (4th Cir. 1999); *Brown v. Rock Creek Mining Company, Inc.*, 996 F.2d 812, 816 (6th Cir. 1993); *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1099 (4th Cir. 1993); *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3rd Cir. 1989). Thus, the standards are the same under the new and old regulations.

As discussed above, various items of evidence in this case addressed this issue. Miner's cause of death was listed on his death certificate by Dr. Robinette. Miner's medical records also outline his diagnoses at the time of his death. Opinions on Miner's cause of death were offered by Drs. Fino, Castle, and Perper. Additionally, Drs. Hudgens' and Naeye's autopsy reports discuss Miner's death as well.

Dr. Robinette attributed the Miner's cause of death from respiratory failure (secondary to pneumonia) to coal worker's pneumoconiosis on the death certificate. (DX 9). In the Discharge Summary for the terminal (May 29 to 31, 2003) hospitalization, he stated that the autopsy findings were felt to be compatible with underlying coal workers' pneumoconiosis and usual interstitial pneumonitis complicated by severe coronary artery disease and congestive heart failure. As "Diagnoses at the Time of Death," he listed respiratory failure secondary to two forms of pneumonia, pulmonary fibrosis with simple pneumoconiosis, congestive heart failure with cor pulmonale, and diabetes mellitus. (DX 11).

Drs. Fino (who conceded Miner had pneumoconiosis) and Castle (who believed Miner did not have pneumoconiosis) did not personally review the pathological evidence, but concluded that Miner's death was not the result of coal dust exposure or pneumoconiosis. Both doctors concluded that Miner died from respiratory failure as a result of usual interstitial pneumonitis. (EX 9; EX 11). Additionally, both physicians concluded that Miner would have died in the same manner even had he not been employed in coal mines. (EX 9; EX 11). Of particular importance to both physicians was the fact that Miner was not hospitalized with severe breathing problems until 1997 -- nearly twenty years after he ceased working in coal mines -- a position that is arguably at odds with the amended regulations. According to both physicians, this, coupled with his death five years later, demonstrated that he had developed pulmonary

fibrosis which led to his death, unrelated to coal mine dust. (EX 9; EX 11). Dr. Fino further opined that even with pneumoconiosis present in his lungs, Miner's cause of death had nothing to do with it. (EX 9, EX 14 at 18).

In the autopsy report, Dr. Hudgens found the coexistence of simple coal workers' pneumoconiosis and the usual interstitial pneumonitis. Specifically, he noted the existence of (1) anthracotic macules and silicotic nodules with surrounding accumulations of black pigment and emphysema and (2) a diffuse fibrotic process unassociated with the anthracotic pigment. He did not comment upon the etiology of the latter condition or the relative contribution of the two conditions to the Miner's death. (DX 8).

Relying largely on the pathological evidence presented to him, Dr. Naeye concluded that Miner's death was not related to pneumoconiosis. (EX 6, EX 8). Like Drs. Castle and Fino, Dr. Naeye found it significant that Miner did not report any irregularities in his lungs until 1997. (EX 8, EX 13 at 30). Dr. Naeye concluded Miner's death was not caused or hastened by coal dust exposure or pneumoconiosis. (EX 13 at 34).

Dr. Perper, by contrast, determined pneumoconiosis was the primary cause and a hastening factor of Miner's death. (CX 3). Dr. Perper concluded that because normal lung tissue was replaced by non-breathing pneumoconiotic lesions associated with centrilobular chronic emphysema, Miner suffered pulmonary insufficiency which also led to resulting hypoxemia and emphysematous bullae. *Id.* In other words, the pneumoconiosis replaced healthy lung tissue, which led to Miner's respiratory failure. *Id.*

Because of the conflicting reports, I must weigh the opinions. The starting point in this analysis is the physicians' conclusions on pneumoconiosis. As discussed above, the evidence sufficiently establishes that Miner was suffering from pneumoconiosis at the time of his death; Drs. Castle and Naeye disagree. Nevertheless, where a physician's opinion is based on findings contrary to an administrative law judge's findings, it may be accorded less weight. *See Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002); *see also Toler v. Eastern Assoc. Coal Co.*, 28 F.3d 416 (4th Cir. 1995). Since Drs. Castle and Naeye rendered an opinion on Miner's death that did not involve the presence of pneumoconiosis, which I have found, both of their opinions regarding Miner's cause of death shall be accorded less weight. Additionally, as also discussed above, neither Drs. Fino nor Castle are pathologists. However, both doctors relied on the pathological evidence in this case to reach their opinions. Because they did not actually review the pathological evidence or were even capable of personally interpreting it, I accord their opinions even less weight.

For the reasons set forth above, I have decided that Dr. Perper's findings should be accorded greater weight than those of the other physicians and I am persuaded more by his conclusions, which were based upon his findings of clinical and legal pneumoconiosis. Despite assertions to the contrary by Employer's physicians, Dr. Perper did not ignore the usual interstitial pneumonitis in Miner's lungs; rather, he found that coal dust caused it. (CX 3). As such, I believe Dr. Perper properly took both of these into account when he determined that coal workers' pneumoconiosis contributed to Miner's death. Therefore, I find that Claimant has proven by a preponderance of the evidence that Miner's death was due to pneumoconiosis.

### **Conclusion**

Because I have determined Miner was suffering from pneumoconiosis at the time of his death, which arose from his coal mine employment, and that pneumoconiosis hastened his death, I award Claimant benefits.

### **Onset Date**

Under 20 C.F.R. §725.503(c), the date for commencement of benefits in a survivor's claim is the month of the miner's death. The evidence in this claim establishes that Miner died on May 31, 2003. (*E.g.*, EX 9). As such, benefits shall commence as of May 1, 2003.

### **Attorney's Fee**

No award of an attorney's or representative's fee is made herein because no fee application has been received. *See* 30 U.S.C. §932; 33 U.S.C. §928. The Claimant's attorney shall have thirty days for submission of a fee application in conformance with 20 C.F.R. Part 725 and the other parties shall have thirty days to file any objection. These periods may be extended by the stipulation of the parties.

### **ORDER**

**IT IS HEREBY ORDERED** that the claim of E.B. for black lung survivor's benefits be, and hereby is, **GRANTED** with an effective date of May 1, 2003 and the Employer/Carrier shall commence payment of benefits and reimburse the Trust Fund for payments previously made.

**A**

PAMELA LAKES WOOD  
Administrative Law Judge

Washington, DC

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence

establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).